2.0 PERSONNEL

2.1 Policy: Each jurisdiction must have an MCH Director and a Perinatal Services Coordinator (PSC) that is approved by the State MCH. MCH Branch must approve all changes to the jurisdiction's MCH Director and PSC, including allocated time, duties, job specifications, and organization charts. Refer to the Federal Financial Participation Section of this manual.

2.2 MCH Director Requirements:

2.2.1 The MCH Director must be a qualified health professional, defined as:

- A physician who must be board-certified, or board-eligible, in specialties of OB/GYN, Pediatrics, Family Practice, or Preventive Medicine; or
- A non-physician who must be a certified public health nurse (PHN).

2.2.2 The MCH Director will dedicate a percentage of time to MCH activities that complies with the following MCH State Guidelines for the population.

MCH Director Chart
Health Jurisdiction Full-Time Equivalent

Total Population	FTE MCH Director
3.5 million	2.0 Physicians
750,001-3.5 million	1.0 Physician
200,001-750,000	1.0 Public Health Nurse
75,001-200,000	.75 Public Health Nurse
25,000-75,000	.50 Public Health Nurse
<25,000	.25 Public Health Nurse

2.2.3 All MCH Directors funded in whole or in part by the MCH Allocation Plan and Budget will be the lead for the local MCH program in the health jurisdiction.

2.2.4 The MCH Director, in collaboration with the local health officer, will have general responsibility and authority to plan, implement, evaluate, coordinate, and manage MCH services in the local health jurisdiction.

2.2.5 The MCH Director's role as the head of the local MCH program is to direct the local program to perform the core public health functions of assessment, policy development,

assurance, evaluation, and the implementation of the approved SOW. The core functions are discussed below:

- **Assessment**
  - Participate in MCH Branch-sponsored training on data sources, data management, preparation of data for analysis, and the translation of data into information for program planning.

  - Monitor local health status indicators for pregnant women, infants, and children using standardized data techniques for the purpose of identifying at-risk populations, understanding the health needs in the community, and identifying barriers to the provision of health and human services for MCH populations.

  - Identify health issues and interact with local health care providers and key informants to enhance programs and improve outcomes.

- **Policy Development**
  - Use information gathered during assessment to develop and implement local policies and programs to implement interventions.

  - Develop plans and direct resources consistent with program goals and objectives.

- **Assurance**
  - Facilitate access to care and appropriate use of services. This may include patient/client education and community awareness, referral, transportation, childcare, and translation services and care coordination.

  - Must have a toll free or ”no cost to the calling party” telephone system which provides a current list of available culturally and linguistically appropriate information and referral to community health and human resources and the general public regarding access to prenatal care. The telephone number must be disseminated widely throughout the health jurisdiction by means of pamphlets, publications and media publicity. At a minimum, the toll free line must be operational during normal business hours and must be linguistically appropriate. Personnel staffing

the toll-free line should have cultural sensitivity training. After-hours messages must be answered by the end of the following business day.

- o Coordinate all MCH patient/client education and community awareness services from various programs to prevent duplication of service and for optimal use of resources.

- o Participate in quality assurance activities in order to improve community health indicators for women, children, and families.

- o Attend Maternal Child and Adolescent Health Action meetings and other required trainings.

- **Evaluation**
  - o Based on activities of assessment, policy development, and assurance, evaluate program and modify program to ensure best practices.

  - o Include in selected local priority activities methods of measuring outcomes and evaluating progress toward achieving both state and local MCH objectives. This evaluation is included in the semi-annual and annual reports to the state MCH Branch.

2.3 Perinatal Services Coordinator (PSC) Requirements:

2.3.1 Based upon the local birth rate, each health jurisdiction must have a PSC that meets the time and professional requirements identified in the table below. When determining the appropriate FTE for a jurisdiction, consider the number of Medi-Cal births and obstetric providers, and geographic issues.

PSC Chart
Health Jurisdiction Full-Time Equivalent*

Total Number of Births	FTE PSC
100,000	2.0 SPMP
20,001-100,000	1.0 SPMP
5,001-20,000	.75 SPMP
1,000-5,000	.50 SPMP
<1,000	.25 SPMP

2.3.2 Process applications for those eligible providers desiring to become approved CPSP providers.

2.3.3 Provide consultation and technical assistance to prenatal care providers including FQHC/95-210 clinics and managed care plan contractors, in the implementation of Title 22, CCR Sections 51170 et seq. relating to comprehensive perinatal services.

2.3.4 Assist providers to deliver CPSP services in accordance with Title 22 California Code of Regulations.

2.3.5 New PSC must attend a new coordinator orientation.

2.3.6 Attend state-sponsored PSC meetings and other required trainings and related activities, such as task force committee for coordination and operation of this program.

2.3.7 Must participate in the functions of assessment, policy development, assurance, and evaluation as discussed below and assist in the implementation of the local CPSP:

- **Assessment**
  - Monitor trends in access and quality of prenatal care, including the adequacy of the obstetrical provider network and its ability to meet the needs of the target population; and

  - Identify areas that have disproportionately high need in relation to access to care and other barriers to the delivery of appropriate and timely prenatal care, e.g., substance abuse, ethnic/cultural groups.

- **Policy Development**
  - Use information gathered during assessment to develop and implement local policies and programs to implement interventions.

  - Participate in local planning to address unmet needs to provide access to first trimester care for all pregnant women.

- **Assurance**
  - Undertake quality assurance activities, as appropriate, with CPSP providers and managed care

plans and participate in regional and statewide CPSP advisory committees/workgroups.

- Address issues related to access and quality of perinatal care.

- Assure the availability of comprehensive perinatal services to all Medi-Cal-eligible women in both fee-for-service and capitated health care systems.

- Facilitate meeting the needs of providers and managed care plans for updated materials, resources, and information on CPSP and the needs of the target population.

- Work with the perinatal community, including providers, managed care plans, and other health and human service providers to reduce barriers to care, avoid duplication of services, and improve communication.

- Inform the perinatal community, including providers, managed care plans, and other health and human service providers about local status and trends of perinatal outcomes and their relationship to the MCH yearly plan.

- Educate the provider community, including providers, managed care plans, and other health and human service providers about CPSP, the needs of the target populations and sub-populations, such as the homeless, substance using, and migrant workers, etc.

- Collaborate with providers and other third-party payers to extend comprehensive perinatal care to all pregnant women at or below 200 percent of poverty.

- Conduct provider education and continuous quality improvement programs that will reduce perinatal mortality and morbidity.

- Promote, develop, and coordinate professional and community resources that will serve the multidisciplinary needs of the pregnant woman and her family.

- **Evaluation**
  - Based on activities of assessment, policy development, and assurance evaluate program and modify program to ensure best practices.

  - Incorporate assessment findings and activities to improve services (if indicated) in the jurisdiction's Community Profile and Local MCH Plan.

2.4 Procedures for Key Personnel:

2.4.1 Maintain documentation of activities on file (Refer to Audit Section of this manual).

2.4.2 **Annual Reports**--Summarize activities and describe outcomes/impact in the Annual Reports in accordance with current fiscal year Policies and Procedures.

2.4.3 **Key Personnel**--Notify MCH Branch Chief in writing of resignation of key personnel within seven days of resignation notice.

2.4.4 **Selection of Candidate**--Send a letter to MCH Branch Chief notifying them of the candidate selected within seven days of selection of the candidate. This letter will include qualifications of selected candidate, their license(s) number, and effective start date. MCH will respond within seven days as to approval of candidate. If the candidate does not meet requirements, the agency may request a waiver to the requirement. MCH Branch will consider a waiver to key staff policy if an agency is unable to provide the full-time equivalent for either the MCH Director or PSC at the time allocations detailed in the requirement charts. A Key staff waiver is for a specific person and remains in place only as long as that person occupies the position for which the wavier is approved. If the person who was issued a wavier changes positions or leaves employment with the agency, the waiver is void. MCH will not reimburse an agency for MCH Directors and PSC who do not meet the minimum educational and time commitment requirements, unless a waiver is on file in the MCH Branch.

2.4.5 **Revised Duty Statements**--Submit revised duty statements, job specifications, organizational charts, Medi-Cal justification, and annual budget if the proposed change

involves a change in the allocated time (full-time equivalent) or involves new or changed duties.

2.4.6 **Key Staff Waiver**--Submit to MCH Branch a written request for a key staff waiver that outlines the circumstances for the waiver and the qualifications of the person or persons who will be filling the position. MCH will respond within seven days of receiving the request. Submit a copy of the approved key staff waiver with the Annual Report along with an explanation for continuing the waiver with other documents for the Allocation Funding Application (AFA) negotiations.

2.5 Duty Statements Requirements:

2.5.1 As a part of the AFA, current duty statements for personnel identified on the budget shall be used as supporting documentation for the percent of time assigned to MCH program activities and level of Federal Financial Participation (FFP) match. Duty statements must:

- Accurately reflect the MCH activities.
- Contain only those duties performed for the MCH program, or specific program duties.

Refer to MCH Forms/Exhibits Duty Statement Template

2.5.2 Duty statements must provide sufficient information, i.e., targeted populations, targeted geographic areas, specific practice settings or specific functions, to justify the matching level of Medi-Cal administrative claiming (FFP) that is requested. Duty statements <u>need not</u> include the percents of time for Medi-Cal administrative claiming (FFP) that is requested on the Budget.

2.5.3 The description of duties contained in the Duty Statement will be consistent with:

- The Position Title on the Personnel Detail Sheet of the Budget
- The level of Medi-Cal administrative claiming (FFP) requested on the Budget
- The Budget Justification.

2.5.4 Duty Statements for Skilled Professional Medical Personnel (SPMP) will note ‘SPMP’ at the top of the Duty Statement or along with the position title.

2.5.5 Agency job specifications must signify they require SPMP, if enhanced funding match is claimed.

2.5.6 All personnel funded through the local MCH Budget need duty statements, which describe those activities funded through the MCH Allocation or directly related to the MCH program. The titles should match those on the organizational chart, budget, and budget justification.

2.6 Procedures:

2.6.1 Maintain on file a copy of the county's duty statements and job specifications for SPMP positions and all duty statements. This must be available to the MCH Branch upon request.

2.7 Organizational Charts Requirements:

2.7.1 Each agency must have an organization chart for all MCH programs and any special programs they have which:

- Identifies the MCH program and its relation to other public services for women and children;
- Illustrates the relationship of MCH personnel and programs to the MCH Director, the local health officer, and overall agency; and
- Identifies all staff positions funded through MCH funds or involved in MCH activities. Staff positions should match the duty statement titles. The budget line number, and initials of the staff member should be listed on the organizational chart for ease of identification with the positions in the budget and budget justification.

2.8 Procedure for Organizational Chart:

2.8.1 The local organizational charts are submitted to MCH as a part of the AFA, along with the current duty statements for Personnel identified on the budget and shall be used as supporting documentation for the percent of time assigned to local MCH program activities and the level of FFP match.

2.9 Training and Meeting Requirements:

2.9.1 Adequate funding for training and meeting expenses, including travel, must be built into the annual budget.

2.10 Procedures for Training and Meeting Requirements:

2.10.1 Include as a line item in the budget adequate funding for training and meeting expenses.